Draft Meeting Summary
Freestanding Medical Facility Work Group Meeting
Wednesday June 22, 2016
MHCC, 4160 Patterson Avenue, Baltimore, MD 21215

Work Group Member Attendees:
Claudia Balog
Marta Harting (representative for Kaiser Permanente)
Robert Jepson
Jeff Johnson (substitute for Neil Moore)
Robin Luxon (by phone)
Brett McCone
Lisa Myers (by phone)
Amy Perry
Rachelle Pierre-Mathieu (by phone)
Renee Webster
Jennifer Wilkerson
Patti Willis

MHCC Staff Attendees:
Eileen Fleck
Paul Parker
Kathy Ruben
Ben Steffen
Suellen Wideman

Introductions

The meeting convened at approximately 10 .a.m. Eileen Fleck, Chief of Acute Care Policy and Planning, thanked everyone for attending the work group meeting and explained that there were several changes in the work group membership since the last meeting in 2015. There is no longer a representative for Kaiser Permanente because the former representative, Lisa Adkins, left Kaiser Permanente. Robin Luxon replaces Dean Kaster, as the representative for the University of Maryland Upper Chesapeake Health because Mr. Kaster retired. A representative for 1199 SEIU United Health Care Workers East has been added, Claudia Balog. Ms. Fleck then asked the work group members to introduce themselves.

Ms. Fleck explained that the focus of the meeting would be on the changes that were made to the draft State Health Plan chapter ("Chapter") as the result of the 2016 legislative session. Ms. Fleck said that although the MHCC staff revised the draft Chapter in response to informal public comments, the work group meeting would focus on additions to the draft Chapter pertaining to exemptions from Certificate of Need ("CON") review. Hospitals that want to convert to a freestanding medical facility ("FMF") may seek an exemption from CON

review. Ms. Fleck then asked Paul Parker, Director of the Center for Health Care Facilities Planning and Development to give a brief overview of Senate Bill 707.

Overview of Legislation Allowing for an Exemption from CON Review

Mr. Parker explained that Senate Bill 707 is the 2016 legislation that allows a general hospital to convert to a freestanding medical facility. Mr. Parker explained that previously Maryland general hospitals seeking to eliminate inpatient services and maintain a limited number of outpatient services only had the option to transition to a limited service hospital (LSH) through obtaining an exemption from CON. However, Mr. Parker noted that no hospital in Maryland has converted to an LSH. The objective of Senate Bill 707 was to allow for the transition from a general hospital to a freestanding medical facility (FMF) through an exemption from CON. Mr. Parker noted that FMFs, unlike LSHs, have been established in Maryland.

The law allows a general hospital to apply for an exemption from CON review, which is a less onerous and quicker process than a CON, but it still requires action by the Maryland Health Care Commission ("Commission"), either approval or denial of the request. In order to approve an exemption, the Commission needs to find that the hospital's conversion to an FMF is in the public interest, that it will improve the effectiveness and efficiency of care and that it is consistent with the State Health Plan (SHP). He also noted that the state-wide emergency board must find that the conversion of a hospital to an FMF will maintain adequate and appropriate emergency care within the state-wide emergency system. Mr. Parker explained that the key objective of the meeting would be to discuss the standards and criteria for exemptions from CON review.

Mr. Parker explained that another key requirement in Senate Bill 707 provides that a general hospital seeking to convert to an FMF must hold an informational hearing before the transformation. The hospital will have to perform specific plan development before the hearing takes place. Mr. Parker noted that Senate Bill 707 also establishes a work group on rural healthcare delivery that will focus on how to maintain adequate access in rural areas. He noted that the work group for this initiative is in the process of being formed and will meet within the next month.[1]

Ms. Fleck thanked Mr. Parker for his overview, and then explained that Kathy Ruben, Health Policy Analyst with MHCC, would discuss requirements for establishing an FMF through an exemption from CON. Ms. Fleck suggested that it may be helpful for work group members to look at a copy of the draft Chapter for the following discussion.

[1] The first meeting of this group was not convened in July. It is scheduled for August 30, 2016.

Criteria for Establishing an FMF through an Exemption from CON

Ms. Ruben noted that she would be discussing both the procedural requirements for filing an exemption from CON review, as well as the requirements regarding the location of an FMF. She then read the draft language of the first part of the exemption standard, COMAR 10.24.19.04C(1).

> *"A freestanding medical facility created through the conversion from a general hospital shall only retain patients overnight for observation stays."*

Ms. Ruben emphasized that as stated in Senate Bill 707, through conversion to an FMF, the hospital eliminates the capability to admit or retain patients for overnight stays. She then asked the work group if there were any questions or comments about this standard. There were none.

Procedural Requirements for Filing Notice

Ms. Ruben continued to read the requirements for filing a notice of intent to seek an exemption from CON to establish an FMF and the stipulations for providing the general public with notice before an informational hearing in draft COMAR 10.24.19.04C(2), as shown below. She also noted that MHCC staff plans to clarify throughout the section whether the referenced hospital is the converting or the parent hospital or both hospitals.

> *A complete notice of intent to seek an exemption from Certificate of Need review to convert a general hospital to an FMF shall:*
>
> *(a) Be filed in the form and manner specified by the Commission;*
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> *(b) Be filed with the converting hospital and its parent hospital as joint applicants;*
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> *(c) Only be accepted by the Commission for filing after:*
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> *(i) The hospital publishes on its website and otherwise makes available to the general public and community stakeholders, at least 14 days before holding a public informational hearing, the hospital's proposed transition plan that addresses, at a minimum, job retraining and placement for employees displaced by the hospital conversion, plans for transitioning acute care services previously provided on the hospital campus to residents of the hospital service area, and plans for the hospital's physical plant and site.*

Ms. Ruben continued to read the specific language pertaining to the requirement for a public informational hearing in draft COMAR 10.24.19.04C(2)(ii), as shown below.

"The hospital, in consultation with the Commission, and after providing at least 14 days notice on the homepage of its website and in a newspaper of daily circulation in the jurisdiction where the hospital is located, holds a public informational hearing that addresses the reasons for the conversion, plans for transitioning acute care services previously provided by the hospital to residents of the hospital service area, plans for addressing the health care needs of residents of the hospital service area, plans of the hospital or the merged asset system that owns or controls the hospital for retraining and placement of displaced employees, plans for the hospital's physical plant and site, and the proposed timeline for the conversion."

Ms. Ruben explained that Senate Bill 707 includes very specific requirements for the content of the public informational hearing. It also identifies who must receive a written summary of the hearing. As shown below, she then read the draft language in COMAR 10.24.19.04C(2)(iii).

"Within ten days after the public informational hearing, the hospital provides a written summary of the hearing and all written feedback provided by the general public and from community stakeholders to the Governor, Secretary of DHMH, the governing body of the jurisdiction in which the hospital is located, the local health department and local board of health for the jurisdiction in which the hospital is located, the Commission, and the Senate Finance Committee, House Health and Government Operations Committee, and members of the General Assembly who represent the district in which the hospital is located."

Ms. Ruben then asked if there were any questions or comments about the requirements for the public informational hearing or the written summary of the hearing. Claudia Balog, the representative for 1199 SEIU United Healthcare Workers East, asked if there was a reason why the hospitals would not be required to touch upon some of the information provided to the Commission, such as the availability and accessibility of emergent, urgent, and primary care services, or the extent to which the conversion is consistent with the most recent Health Needs Assessment. She explained that her concern is that the general public will not have all of the necessary information to provide comments following the public informational hearing.

Mr. Steffen pointed out that the hospital's acute care services transition plan would be available, which would cover these items. He also explained that the Commission is making plans to have the hospital's transition plan available to the public. Ms. Balog said that she just wanted to verify that the information that is available to the Commission is also available to the public. She commented that the more detail that is available to the public, the better. Ms. Fleck said that she understood the concern, and she proposed allowing the public to weigh in later if there is new information available. She suggested that the work group could revisit the issue when it discusses the "public interest" section. Mr. Steffen reminded everyone that the Commission keeps public records of CON regulations that are available to everyone. He said that the records of the

exemption process would also be public. Ms. Ruben then asked if there were any other questions or comments.

Amy Perry, the President of Sinai Hospital of Baltimore stated that she is very much in favor of the hospital explaining its plans and having a clear transition plan. However, she said that the downsizing hospital's responsibility to place and retrain all of the employees that work for the facility is unclear. Mr. Steffen responded that the language of SB 707 specifically states that the hospital should have a plan in place for retraining and placing displaced employees. Mr. Jepson, the Vice President for Business Development for Washington Adventist Hospital, stated that his understanding is that hospitals should have a plan, but the hospital is not necessarily expected to place all displaced employees. He added that the requirement should not hold up the CON exemption process. Mr. Steffen commented that the vision of the legislature was not that the hospital alone would retrain and try to place employees, but that the hospital would be helped by other agencies. Mr. Jepson stated that most organizations will try to place employees, but there is no guarantee. He noted that this is a fair point to flag since the incentive for a hospital is to reduce capacity. Renee Webster, from the Office of Health Care Quality said that the intent was for the hospital to use as many employees as possible. She gave as examples: training within the hospital system to place employees and providing referrals. Mr. Jepson commented that the unfortunate reality of downsizing is a loss of jobs. Ms. Balog stated that the intent was to try to retrain, and there is certainly not an expectation of guaranteed placement. She added that SEIU also has a fund to help displaced employees.

Ms. Ruben asked again for additional questions on this section of the draft. Martha Harting asked whether a hospital filing for a CON exemption to establish as FMF must be part of a hospital system. Mr. Parker noted that, by definition, an FMF must be an administrative part of a general hospital. Thus, a stand-alone independent hospital does not have the option of obtaining an exemption from CON to establish an FMF. Ms. Webster noted that an FMF needs to be an administrative part of a hospital in order to have provider-based status for payment from Medicare. Mr. Steffen commented that LSH provisions continue, but it would be unlikely that an independent hospital would choose that option. Ms. Ruben asked if there were any other questions or comments on the issue. Since there were none, Ms. Ruben read the last part of the draft COMAR 10.24.19.04C(2)(iv), as shown below. There were no questions or comments on it.

> *The hospital provides any additional information determined by Commission staff as necessary for the notice to be complete.*

Requirements Regarding the Location of an FMF

Ms. Ruben read draft COMAR 10.24.19.04C(3), as shown below, and asked if any work group members had comments.

(3) The Commission shall require that a freestanding medical facility created through the conversion of a general hospital remain on the site of, or on a site adjacent to, the converting general hospital unless:

(a) The converting general hospital is the only general hospital in the jurisdiction or is one of only two general hospitals in the jurisdiction and both belong to the same merged asset system; and

(b) The site is within a five-mile radius and in the primary service area of the converting general hospital.

Jeff Johnson, the representative for Dimensions Healthcare, asked if a health system could either convert a hospital to an FMF within the existing structure or build a new structure. MHCC staff confirmed that a health system has both options. Mr. Johnson then asked if the capital threshold would be considered when an FMF is proposed through the CON exemption process. Ms. Fleck explained that the requirement for CON review is usually triggered for projects over a certain expenditure level, but it would not be triggered with the CON exemption process for establishing an FMF. Mr. Steffen noted that it would be illogical to establish an exemption process that conflicts with the capital threshold for CON review. He pointed out the specific language in statute that addresses this issue.

Mr. Johnson then asked if a hospital proposing to convert to an FMF, through a CON exemption process, would be allowed to have operating rooms ("ORs"). He commented that he thought that would be the case, but with a different model of establishing an ambulatory surgery center, outside of the rate regulation structure, a CON would be required. Mr. Steffen noted that MHCC staff had not discussed the first scenario described by Mr. Johnson. Mr. Steffen added that the idea was not to have a hybrid model that would transition into an ambulatory surgery center, although there could be OR space within an FMF. Mr. Parker noted that it would be a separate licensing category and that FMFs are only for emergency services. Mr. Brett McCone, Vice President of the Maryland Hospital Association, pointed out that in SB 707, Health-General 19-201 was amended to indicate that FMFs may provide outpatient services other than emergency services and obtain rates for these services from HSCRC potentially. Suellen Wideman, an Assistant Attorney General for the MHCC, explained the HSCRC regulations were intended to allow hospitals to get rates for outpatient services and not to control the approval or disapproval of ORs in health care facilities. She noted that the Commission is working on regulations that allow one-OR ambulatory surgery centers to expand to two ORs through an exemption process without the CON process.

Ms. Amy Perry, President of Sinai Hospital expressed a concern about FMFs expanding beyond their original intent, e.g., byto becoming ambulatory surgery centers. She explained that the purpose of the CON exemption for a hospital converting to an FMF is to improve efficiency by decreasing capacity while still providing for the health care needs of residents in the State. She reminded the group that the health care delivery system is under one global cap of resources, and the waiver for the State could go away if the State fails to control the total cost of care, which includes unregulated ambulatory surgery centers. Mr. Johnson commented that he viewed the situation differently. He stated that the State is trying to transition facilities and downsize services, but at the same time develop a model of facility that offers comprehensive services to

meet the needs of a particular community, and the Chapter should clarify what services are allowed in an FMF, including surgical services. Ms. Webster noted that if surgery is offered, it should be a separate facility and not change what an FMF was intended to be. She commented that she did not think the licensing law would allow for the provision of surgical services in an FMF. Mr. Jepson shared Ms. Webster's concern about moving away from the original intent of an FMF. He noted that an FMF can still have clinic-type services adjacent to the FMF under the rate-setting process. Mr. Steffen stated that a facility with two operating rooms should still go through the CON process. Mr. Parker agreed that if a general hospital was converting to an FMF and wanted to add an ambulatory surgery center, then it would be required to go through a CON process.

Ms. Wilkerson commented that it seems unnecessary to require a hospital seeking to convert to an FMF to go through a CON review, after obtaining approval to convert to an FMF, in order to continue providing services that it already had been providing. Mr. Parker noted that if an FMF wanted to include only one-OR, then it would only need to obtain a determination of coverage, but CON review would be required for the addition of two or more ORs. Mr. Steffen replied that the change in law expanded the ability of an FMF to allow for observation beds, and it provides a framework for HSCRC to establish rates for other services. He noted that a hospital converting to an FMF can include one operating room without going through the CON process, or it can include multiple operating rooms through the CON process.

Mr. Johnson brought up that one reason hospitals did not convert to LSHs was because of the lack of rate setting mechanisms. However, he noted that within the LSH regulations, an LSH can offer other types of services including surgery. Ms. Wideman stated that the laws governing LSHs prohibit overnight stays, but Senate bill 707 allows for observation beds. Ms. Webster noted that one problem with LSHs is that Maryland would have to have critical access hospitals built into the State health plan too in order to get Medicare reimbursement, but that category of hospital has not been established in Maryland. Consequently, she noted that the statute, with respect to hospital conversions to limited service hospitals, is flawed and not very functional.

Additional Questions and Comments

Ms. Ruben asked if there were additional questions or comments on the draft for this section. Ms. Luxon asked if the work group wanted to add clarity regarding observation stays in the draft Chapter. Mr. Steffen responded that the statute spells out that observation stays are permitted, and HSCRC establishes rates for those services. He commented that rates for FMFs, as he understands it, are generally below the rates of the parent hospital. Mr. Jepson confirmed that Mr. Steffen's understanding is correct.

Ms. Wilkerson returned to the issue of where an FMF may be located. She noted that five miles is very different in an urban setting as compared to a rural setting. She asked if that

means that a hospital could go through a CON exemption process to convert to an FMF without the involvement of any interested parties. Members of the work group explained that an FMF could only be within a five mile radius of the converting hospital, if it was the only general hospital in the jurisdiction or one of two that belong to the same merged asset system and the location was within the hospital's primary service area. Otherwise, the FMF has to be on the same site as the converting hospital or adjacent to the site of the converting general hospital. Ms. Wilkerson commented that the ability to move within a five-mile radius will impact other hospitals, even in certain urban areas.

Ms. Luxon also asked if the MHCC intends to have regulations regarding the size of an observation room or bay. Ms. Fleck replied that specific requirements are not included in the draft Chapter. Ms. Webster commented that the architectural guidelines have size requirements that OHCQ would use for licensing. She also noted that if observation stays were long, then an FMF would have to feed patients. She expects that the observation stays would be brief. Ms. Luxon asked if the observation stays could extend up to 48 hours, and MHCC staff confirmed that is correct.

Before continuing to the next section, Mr. McCone asked a few questions regarding the conversion of a general hospital to an FMF. He described a hypothetical scenario where a hospital converts to an FMF with emergency and related ancillary services as well observation care. Mr. McCone then asked whether the converting hospital has to file a CON for other services to be approved or whether it would be exempt from CON for those other services, with HSCRC later determining if the FMF will receive regulated rates for those other services. Mr. Steffen stated that legislative discussions addressed adding observation beds to FMFs as well as having surgical services on-site as part of an ambulatory campus. He noted that the intent of SB 707 was to expand what can be offered at an FMF, with some services requiring a CON and others requiring a determination of coverage. The intent was not to create a new licensure category of an ambulatory medical center.

Demonstration of Consistency with the State Health Plan

Ms. Fleck explained that many of the same standards apply to both FMFs that are established to address overcrowding or access and those that are established through conversion of a hospital to an FMF. Ms. Fleck noted that general standards include factors such as the quality of care and provision of charity care. She then read the general standards in the draft Chapter, COMAR 10.24.19.04C(4), as shown below.

> *The applicants shall demonstrate compliance with applicable general standards in COMAR 10.24.10.04A and with applicable standards in this chapter.*
>
> *(5) The applicants shall document that the proposed FMF will meet licensure standards established by DHMH.*

(6) The applicants shall establish and maintain financial assistance and charity care policies at the proposed freestanding medical facility that match the parent hospital's policies and that are in compliance with COMAR 10.24.10

(7) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

(a) Provide the number of emergency department visits and FMF visits by residents in the converting hospital's service area for at least the most recent five years;

(b) Assess the availability and accessibility of emergent, urgent, and primary care services otherwise available to the population to be served, including information on the number and location of other hospital emergency departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any zip code area in the service area of the converting hospital.

(c) Demonstrate that the proposed conversion is consistent with the converting hospital's most recent community health needs assessment;

Ms. Fleck asked the work group members at this point if there were any questions or comments. Since there were none, she then read draft COMAR 10.24.19.04C(7)(d), as shown below.

Demonstrate that the number of treatment spaces and the size of the facility proposed by the applicant are consistent with the low range guidance included in the most current edition of Emergency Department Design: A Practical Guide to Planning for the Future, published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume;

Ms. Fleck noted that this standard is the same standard used for CON reviews to establish an FMF. One work group member asked for clarification of the term "low range." Ms. Fleck explained that, based on the number of visits, the number of spaces should fall within a certain range. She added that applicant's projected number of visits and proposed number of spaces should be consistent with the guidelines. Mr. Parker explained that the "low range" is a categorization of the ED. The ACEP guidelines categorize EDs in one of three ways: low range, mid-range, or high range. Mr. Parker explained that there is a list of criteria used to determine the range in which an ED fits and, by definition, an FMF would be regarded as a "low range" ED. He explained that staff at an FMF would not treat the same severity of cases that staff at a high range ED would treat. Mr. Parker noted that in each range category, based on visit volume, there is a specified square footage per treatment space. Generally, with a low range, he noted that an ED is expected to require less space and is also assumed to be capable of handling a higher number of visits per space, because of the lower average acuity of the caseload.

Mr. Johnson asked if there were any guidelines for the number of observation beds for an FMF. Mr. Parker responded that he was not sure because he only recently received a copy of the latest guidelines. Mr. Johnson expressed concern about the ability to hold patients in the FMF for transfer to a hospital for admission. Ms. Perry noted that the transfer of a patient from the FMF to a hospital is considered to be an internal transport since the FMF is an administrative part of the hospital. Thus, the FMF would be included as part of the observation beds of the whole hospital. The parent hospital must take the FMF patients or the hospital may be violating provider based rules. Patti Willis commented that in a rural area, the distance to the parent hospital is much greater, and observation stays may be longer. Ms. Willis suggested that the rural health study may address the issue. Mr. Parker explained that the MHCC has been using the ACEP guidelines for years, and typically there have not been conflicts with a hospital's proposal and the ACEP guidelines. He noted that hospitals have typically been building less space than the ACEP guidelines indicates to be needed. Ms. Fleck asked if there were other questions before she read draft COMAR 10.24.19.04C(7)(e), as shown below.

Provide utilization, revenue, and expense projections for the FMF, along with a comprehensive statement of the assumptions used to develop the projections, and demonstrate that:

(i) The utilization projections are consistent with observed historic trends in ED use by the population in the FMF's projected service area;

(ii) The revenue estimates are consistent with utilization projections and the most recent HSCRC payment policies for FMFs;

(iii) The staffing assumptions and expense projections are based on current expenditure levels, utilization projections, and staffing levels experienced by the applicant hospital's ED and with the recent experience of similar FMFs; and

(iv) Within three years of opening, the combined FMF and parent hospital will generate net positive operating income.

(f) Demonstrate that the proposed construction cost of the FMF is reasonable and consistent with current industry cost experience in Maryland, as provided in Regulation .04B(5) of this chapter.

Ms. Fleck explained that the purpose of (iv) is to make sure that the FMF is financially viable which is consistent with the approach taken with the CON process.

Demonstration of Efficiency and Effectiveness

Ms. Fleck read the draft standards for efficiency and effectiveness in COMAR 10.24.19.04C(7)(g) and (h), as shown below.

(g) Demonstrate that the conversion to an FMF will result in the delivery of more efficient and effective health care services including an explanation of why the services proposed for the FMF cannot be provided at other area hospital EDs or FMFs and why other less expensive models of care delivery cannot meet the needs of the population to be served.

(h) Demonstrate that the conversion to an FMF will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system, as determined by the State Emergency Medical Services Board, as documented by submission of this determination to the Maryland Health Care Commission.

Ms. Lisa Myers from the Maryland Institute for Emergency Medical Services Systems (MIEMSS) was asked to comment on draft COMAR 10.24.19.04C(7)(h). Ms. Meyers responded that the conversion of a hospital to an FMF will have a significant impact on EMS services, especially in rural areas. She also offered to answer any questions about MIEMSS. Robin Luxon, the Vice President for Corporate Strategy and Business Development for the University of Maryland Upper Chesapeake Health asked Ms. Myers to explain MIEMSS' plans regarding Upper Chesapeake Health's intention to convert to an FMF, including which services may be provided in the FMF. Ms. Myers replied that right now, MIEMSS is using the framework of the three former pilot FMFs. She also described the protocol for transport of patients in place for the FMF in Queenstown and explained that MIEMSS has been discussing whether to open up the pilot protocol for the FMF in Queenstown to other facilities.

Demonstration the Proposed FMF Is in the Public Interest

Ms. Fleck next read draft COMAR 10.24.19.04C(7)(i), as shown below, and asked for comments.

(i) Demonstrate that the conversion is in the public interest, based on an assessment of the hospital's long-term viability as a general hospital through addressing such matters as:

(i) Trends in the hospital's inpatient utilization for the previous five years in the context of statewide trends;

(ii) The financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals;

(iii) The age of the physical plant relative to other Maryland hospitals and the investment required to maintain and modernize the physical plant;

(iv) The availability of alternative sources for acute care inpatient and outpatient services that will no longer be provided on the campus after conversion to a freestanding medical facility; and

(v) The adequacy and appropriateness of the hospital's transition plan;

Hearing no comments, Ms. Fleck next read draft COMAR 10.24.19.04C(7)(i), as shown below. She also explained that MHCC staff subsequently realized that the standard should be modified to include additional language that she read and is shown as underlined in the following text.

(8) The Commission shall decide whether to grant a requested exemption from Certificate of Need within 60 days of receipt of a complete notice of intent from a general hospital to convert to a freestanding medical facility.

The Commission at its sole discretion finds that the proposed conversion is:

(1) Consistent with the State Health Plan;

(2) Will result in more efficient and effective delivery of health care services;

(3) Will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical system as determined by the State Emergency Medical Services Board;

(4) Is in the public interest.

Definitions

Ms. Fleck then asked if there were any comments on the definitions in the draft Chapter. One work group member asked whether the definition for "substantial service area overlap," was adequate. Mr. Parker explained that this term is included in the "impact" standard, and the definition is intended to broaden the zone of impact. In order to facilitate the discussion of the definitions, Mr. Steffen noted which definitions had been added or modified in the most recent draft Chapter posted for comment. He noted that the definitions of "Freestanding medical facility" and "Global budget revenue" were modified, and the website referenced for the "Maryland State Health Improvement Process" was updated.

Renee Webster from the Office of Health Care Quality brought up that certain individuals within a community may not realize that a full hospital has been converted to an FMF. Consequently, the FMF may have walk-in patients with serious medical issues. A discussion of the licensure standards for FMFs ensued, and it was noted that these standards are included in the draft to ensure that project plans presented to MHCC will be licensable.

Next Step

Ms. Fleck explained that the next step would be to post the draft Chapter for informal public comment for a short comment period, ending July 7, 2016. She explained that MHCC staff hope to present a draft Chapter to the Commission for consideration as a proposed permanent regulation at the Commission meeting held on July 21, 2016. If approved by the Commission, she noted that there would be a formal public comment period. MHCC staff would then likely ask the Commission to adopt final regulations if no substantive changes are needed, and the Chapter would potentially become effective in November 2016. One of the work group members asked if there would be a schedule for CON exemption requests to

establish an FMF. Ms. Fleck responded that there will not be a schedule for those requests. Before the work group adjourned, Mr. Steffen again mentioned the creation of a work group for rural health care delivery which includes some of the same members as the FMF work group, and Ms. Fleck thanked the work group members for their participation. The meeting adjourned at approximately noon.

Note: Following this meeting and review of informal public comments, MHCC staff changed its position and recommended that a hospital converting to an FMF should be able to use the same exemption process to seek to retain outpatient surgical capacity to be co-located with the FMF or adjacent to the FMF. This retention of outpatient ambulatory surgical capacity would, under MHCC regulations, create an ambulatory surgical facility (if two or more operating rooms) or a Physician Outpatient Surgery Center (if only one operating room). Staff notes that the Office of Health Care Quality does not make this distinction and requires a Freestanding Ambulatory Surgical Facility license regardless of the number of operating rooms. These changes were in the draft Chapter considered by the Commission and adopted as proposed permanent regulations at the meeting held on July 21, 2016.